

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 15, 2003

**Re: IRO Case # M2-03-1382-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 50-year-old male who was injured on \_\_\_. No details of the injury were provided for this review. After conservative measures failed, the patient underwent anterior cervical discectomy and fusion at C5-6 and C6-7. Post operatively the patient continued to have some intermittent discomfort, but he was working without major discomfort. In late \_\_\_ the patient re-injured himself while working and developed more neck and left shoulder pain. His neurologic examination has been reported as showing no reflex, motor or sensory deficit on 1/27/03. He has had subjective complaints of numbness, but no definite neurologic deficit has been recorded, according to the records presented for this review. Re-evaluation for the neck pain, as far as I can tell from the reports provided, did not include any plain x-rays of the cervical spine. Previous x-rays of the cervical spine after the fusion indicated that the fusion had not taken properly.

Requested Service(s)

Repeat CT scan of the cervical spine

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

AP and lateral with oblique views and flexion and extension views with plain x-rays should suffice in coming to the conclusions sought in a CT scan. More testing might also include an MRI. There is nothing in the operative report to indicate that there is material present that would interfere with an MRI, and also there is nothing in the history provided to indicate some general problem, such as a pacemaker, that would interfere with an MRI.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:  
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669,  
Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,

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In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 17<sup>th</sup> day of July 2003.